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Joe V. Meigs, '19

ROCKY MOUNTAINS

The Rocky Mountain Harvard Medical School Alumni Association announces that the Annual Harvard Lecture will be given on Friday, October 28, by Dr. Joe V. Meigs, Clinical Professor of Gynecology.

This is one of the most interesting activities planned by any of our regional groups. Dr. Meigs will deliver the Lecture at 5:00 p.m. in the Sabin Amphitheater of the University of Colorado Medical Center. That evening there will be an Alumni Dinner in his honor at the Denver Country

Club. To round out the trip, he will present a "live" clinic at the Denver General Hospital on the following morning.

Dr. Meigs is the eighth lecturer to be invited to address the Rocky Mountain Association. In previous years the speakers have been

- 1948 Fuller Albright
- 1949 Marius N. Smith-Petersen
- 1950 J. Howard Means
- 1951 William B. Castle
- 1952 Edward D. Churchill
- 1953 Howard Root for Elliott P. Joslin
- 1954 Paul D. White

The work of the Rocky Mountain group in planning and maintaining this series is indeed a notable achievement.

PENNSYLVANIA

In response to the invitation of Wilbur E. Flannery, '35, 25 doctors and their wives gathered at 6:30 on Thursday, September 22 in the William Penn Hotel in Pittsburgh, Pennsylvania. The event was the second annual dinner meeting of the Harvard Medical Alumni of Pennsylvania. As in the previous year, the

dinner was held during the annual session of the Medical Society of the State of Pennsylvania.

The principal speaker was Russel H. Patterson, '18, Clinical Professor of Surgery at Cornell University Medical College. Dr. Patterson is a member of the Council of the Harvard Medical Alumni Association. In addition he is serving an appointive term as a Director of the Harvard Alumni Association.

His topic for the evening concerned the important role which the Alumni must take in the affairs of the Medical School. Predicating his comments on the need for the closest cooperation between a school and its Alumni, he pointed out that the graduates could render great service as the spokesmen for the school. To do this effectively, the Alumni should make it their business to keep themselves constantly informed of the changes and developments that take place in all phases of the school's operation together with the needs that arise because of these developments.

Although Thomas H. Lanman, '16, Director of Alumni Relations, could not be present, he sent a short message of greeting and congratulation to the group.

The duties of Toastmaster were ably handled by Paul H. Wilson, '28.

LETTERS

Dissonance

To the Editor of the *Bulletin*:

The article "Women at Harvard Medical School" by June Pryor, '55 in April, '54 *Bulletin* was optimistic and encouraging. Her inquiry to me was received too late to be included in the report. Mine was the Class of 1951, memorable in small part for having started with 5 women, being graduated with eight, including the original five.

But my voice will not blend with the happy chorus. I have become the unfortunate anachronism, the unwise one who did not follow the approved path to Psychiatry, Pediatrics, Radiology and Research. The rash one who chose

General Surgery. And after four difficult years in surgical training at a large Boston general hospital, I am blandly told, "Statistics show it does not pay to train a woman."

Were the situation less tragic, it would be downright comical. Did it matter that this hospital had never had a woman in Surgery before me and had no statistics whatsoever regarding the training of such? Did it matter that four long years had proved the fallacy of the old cry, "The training is too hard for girls?" Did it matter that my entire life has been directed toward one professional goal and that nothing short of serious illness or incapacitating injury could cause me to give up my profession? Not one whit. The facts were ignored, fiction was easier to accept.

Few realize how devastating it is to be constantly reminded of the obstacles

to one's progress by someone who is in an absolute position to remove the one then faced. Many have kindly offered to help me go far, far away, somewhere. And with genuine concern for my interests. But the lesson that Boston is the Hub of the Surgical Universe has been learned too well. I will not pass away.

It may be that I shall join the small percentage of medical women who do not practice, but the only reason will be that I have perished at the roadblock erected by my colleagues-in-pants. My goal is a creditable place in General Surgery. And, bolstered by an unyielding Faith that I am capable of this, sustained by an unfaltering trust in myself (my trust in most of my fellowmen having begun to falter long ago), I will persist, I WILL NEVER TURN BACK.

MILDRED F. JEFFERSON, '51

Harvard Medical Alumni Bulletin

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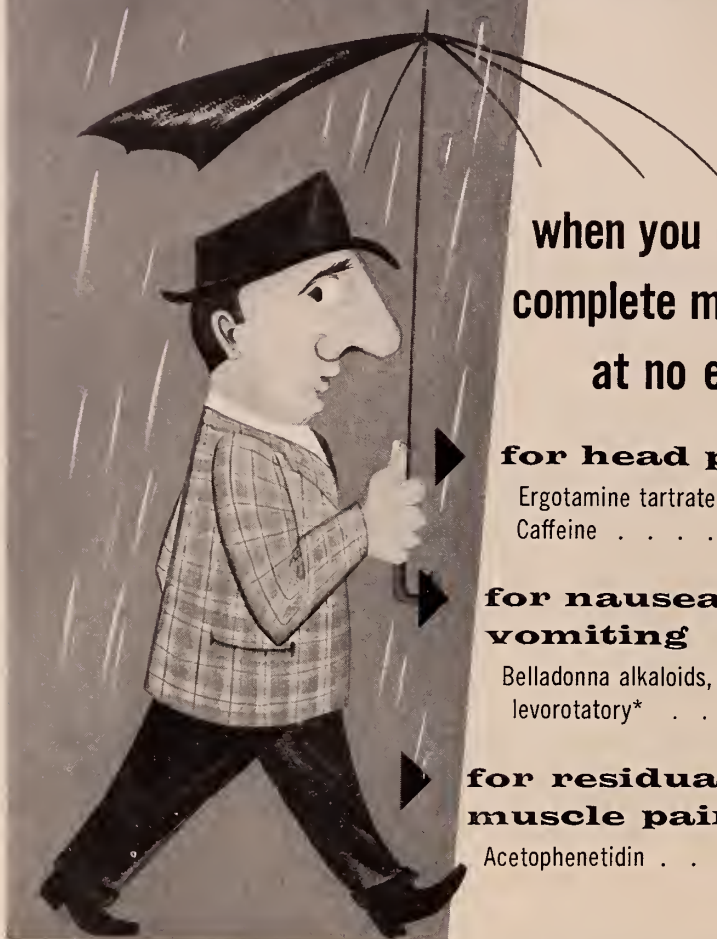
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According to Browne

Rolf Liem, '33

"Bless me in this life with but peace of my Conscience."

Religio Medici by Thomas Browne

Once upon a time there was a young doctor named Jo. Jo may resemble some person of your acquaintance, but any such similarity is purely coincidental. Jo was born in a large city where his father was a Social Service worker, which meant that Jo lived in relative poverty. Still, he was an average American boy, and might have been born in Back Bay, Prairie du Chien, Wisconsin, or on a million-acre ranch in Texas, for Jo was exposed to what are considered the good, standard, American virtues. He learned in one easy lesson not to lie or steal. He stole a loose dime from the kitchen table, and then told his father that he knew nothing about it, for which he received in double measure the generally recognized treatment against such infractions. His youth slipped by uneventfully, for he discovered early that one could get away with a lot of things and be granted all manner of favors so long as one's grades were good.

In college Jo learned that being a good sport and remaining one of the gang was better than trying to develop into a well-integrated eccentric. He drank with the others and accepted hangovers as part of his education, which part, incidentally, he never did master. Jo experimented with sex until he had a working knowledge of the subject, but it did not seem a worthy outlet for more than his cyclical tensions.

There was some indecision about his life's work, and there was a fleeting impulse to be a journalist and report exciting adventures such as murders. He was a good-looking chap, and took a hand in amateur dramatics, and one teacher encouraged him to try the stage. The Puritan overtones in his background made him shy, as if by instinct, away from such a loose life. I do not wish to imply that Jo was a moralist. In matters of personal behavior he was a relativist rather than an absolutist, and he wanted each man to do as he liked so long as he didn't hurt his neighbor. But in his own life he avoided extremes. He was not material for the confirmed hedonist nor the dedicated ascetic.

What attracted Jo to medicine was its evenness, its solidity, its wide application. He had no good answer to the question. "What degree offers you a wider range of choice than an M.D.—research, teaching, public health, army, navy, children, adults, a dozen specialties, general practice?" And so he studied medicine at H.

Jo was a good student in medical school. This statement probably represents a bit of pure tautology, for the students in his medical school were so carefully selected that they were all good. Every last one of them

was a hum-dinger. What I mean to say is that some are better than others, and Jo's name appeared in the roster of the upper third.

He studied the ins and outs of how to get a good internship, and finally decided on the method of striking at the Q hospital. He ingratiated himself to the nurses, let the senior men on the service all but wipe their feet on his coat, Sirred the visiting men on every possible occasion, and generally made himself so welcome that when he finished his tour of relief, everyone said, "He is a good man. We want Jo."

There was something fascinating about surgery that Jo could not resist. The dispatch, the self-assurance, the sharp decisions appealed to him more than the slow, cumbersome vacillation of the medical men, who seemed to be asking endless questions that remained unanswered. The moment of super-drama when the surgeon stroked his knife for the first cut—ah, the X-rays, the histories, the physicals, the lab work, in short, all of the drudgery, were summed up in this point of climax. It was the diagnostic-therapeutic flower in full bloom.

If you have read this far, you must have ascertained that Jo was no dummy. He knew his way around, and he was not one to shy away from any legitimate influence that would gain his desired end. He wanted to be a resident, via the route of assistant resident. This is the sort of stake that required skilful maneuvering, and Jo figured that the Professor was the one to have on his side. What matter about the others then? The Professor was a surgeon of international renown, but everyone in the hospital called him Charley, and that will suffice for our purpose. Jo went to Charley and asked him what he thought about doing some metabolic studies on the liver during anesthesia. Charley went for it in a big way, and by the end of the year Charley and Jo wrote a paper which Charley read at a surgical meeting. Jo was there (by invitation) to say a few words.

It was during his residency that Jo began to have a change of heart about the big-time surgery. I have indicated that Jo was a poor boy. What he lacked in paternal munificence, he made up by tapping available scholarships and fellowships, but there are no honorariums offered for taking a wife, or for the developments that follow naturally from such an undertaking.

Jo went to Charley and said, "I have a wife and growing family, and I am getting out. I will leave the city and go into the country."

"My boy, you are wise," said Charley as he unbut-

toned his vest, placed his feet on the desk and lit a cigarette. "Perhaps you envy me here. Well, since you are leaving I will tell you a secret. I wish that I were going in your place. I have always loved the country, the fresh air, the open fields, the long walks, the afternoons of fishing," and he gave a panegyric of the pastoral life that might well have been taken from one of Virgil's *Bucolics*. Charley stared out of the window, across the tenement roofs, until his eye met the distant harbor. "Actually, Jo, I'm nothing but a glorified secretary. It is a committee here, another there, interviewing students, talking to trustees, trying to balance a budget. Hell, I'm not a scientist. I'm an executive. You at least will be a doctor, a surgeon all of your life."

Charley went on in this vein, and then he started on the serious advice. Charley had no experience in practice. He had traveled the circuit of medical school, intern, resident, and then jumped from one ivory tower to another without ever touching on the area of competition for a living. There was one original sin in Surgery, as Charley saw it—fee-splitting—and there was but one commandment for surgeons, "Don't split fees." He said this seriously, never giving a thought to the fact that those two great moralists, The Lord and Moses, together ended up with a minimum of ten commandments.

"What is fee-splitting?" asked Jo.

"What is fee-splitting?" and Charley sat up straight. "Suppose a doctor asks you to operate on a case, and tells you to collect \$250.00. Then he comes and expects you to pay him \$100.00 out of your fee. That is fee-splitting."

Jo didn't know just where he would settle, but he started making the rounds. Gee, the doctors were surely glad to see him. They had him to dinner, and asked him about this and that, but when the big question came up, "What about your town, can you use another surgeon?" there was a dropping of the voice and a pause. "I'll be perfectly frank. . . ." Fate decided the issue. His wife came along to look over Fairhaven, and at 8½ months she suddenly precipitated and was delivered in the Fairhaven Hospital. That settled the matter, and Jo remained there to practice.

One of Jo's colleagues in Fairhaven was George. For those who measure success by conspicuous consumption, George was immensely successful. He drove a \$4500 car which he exchanged every year; his home was a spacious place where the garden club had its summer fiesta; and he was a Trustee of Old Yankee Trust. What George lacked in medical savvy, he made up with personal charm. George did general practice, and a fair amount of his own surgery. He said to Jo, "I have a difficult hysterectomy to do, and wish that you would operate for me. I will assist." After the operation, George said calmly, "Send her a bill for \$350.00. Give me \$150.00 and you keep \$200.00."

"I can't do that," said Jo. "It's fee-splitting."

George laughed, a good-hearted belly laugh. "Yes,

of course it is. Just wanted to try you out. Glad to see you're honest." He said it in such a way that Jo suspected him of using language to cover up his thoughts.

Jo was amazed at the strange combination of courage and ignorance that resided in George. George was often over his head the minute he opened the abdomen, and Jo had to explore the common duct for him and extract a stone, when George had meant to settle for a cholecystectomy in a jaundiced patient. Mrs. K developed severe ileus after George did an appendectomy, and Jo did the honors of Levin tube and fluid balance. She just squeezed through, but George had meant to do nothing. "Ah, leave them alone. They all get well," he said. For these services, George collected handsome fees, and Jo took a small assistant's fee.

To repay Jo, George sent him a patient for a Miles resection and another for thyroidectomy. George said, "Let's send our own bills on these cases." The patient came to Jo's office and said, "Thanks a lot for being so reasonable, doctor. Here's your \$150.00 and now I am going over to pay Dr. George his \$200.00." Charley had warned Jo about fee-splitting, but what was this game of I-keep-you-out-of-trouble-so-that-you-will-send-me-some-surgery,—case-splitting, perhaps?

Jo said to himself, "This is not fee-splitting, because we send our own bills and I do not pay George anything under the table. The American Medical Association says that each doctor should send his own bill for services, but that is obviously not the whole answer." He was not at ease, and he began to lie awake nights thinking about his relations with George. He hadn't been to church for some time, but in the back of his mind recurred the story of the Scribes and the Pharisees—the men who were letter-perfect in their adherence to the law, but who were morally bankrupt. In desperation he decided to talk to George, who seemed approachable on any subject—a hearty fellow that one could engage in a "How about this?" sort of conversation.

George was ready for him, and began to talk very fast, as if he were inspired. It sounded rehearsed, so smoothly did he spill the words, "Glad that you asked me about it, Jo. Sure I'll talk about it, anytime. I must say that I wondered about this too when I first began. Everybody does, if he has a conscience. My first come-uppance was when I called Dr. B, a wheel in the College, to operate here on one of our bankers. He came down, removed the Ca of the caecum, and guess what he charged? \$3000.00. And what do you suppose he told me to charge? \$1500.00. There is the prime evil of medicine. Surgeon's fees have been 'according to the patient's ability to pay.' Sounds reasonable and honest, doesn't it? Well, you know what it means in practice—all that the traffic will bear. And according to the rules it is right, decent and correct. So what happens when a G.P. charges all that the traffic will bear? He is a gouger."

George was warming to his subject. He paced up and

down in his office as he spoke. "Here is the clinic in Fairhaven." George was referring to a surgeon, an internist, a pediatrician and an obstetrician who had organized a group practice. "As I understand it, they all get the same pay, regardless of who does what. What do you call that? Because it is done by a C.P.A., does that make it anything but 50-50 all around? It's such a flagrant case of fee-splitting that people are blinded by its arrogance. One of the arguments against fee-splitting is that the patient often doesn't get to the best doctor. Suppose you go to a clinic. You know that they can't have the best man in every field, but will they ever refer you to anyone but a doctor who is friendly to or connected with the clinic? Try it and see."

Here was something to mull over, and Jo came up with some sad conclusions. There was not only fee-splitting, but equivalents of fee-splitting which were fully as reprehensible, but so much more difficult to expose. He would talk to Dr. Frank, who was another G.P. in Fairhaven. Frank was a modest, retiring sort of fellow who plugged along steadily night and day. He didn't say much because he was so busy giving the people a 24-hour service. Frank seemed to have his head screwed on tightly and never went off on a tangent, raised his voice, or rang doorbells for causes.

Frank nodded and chuckled to himself as Jo unfolded his story, and when he began, his reply was couched in a soft, gentle voice. "You see, Jo, I know George pretty well, because we were in medical school together and we interned at the W Hospital. He has just the same training as I do, and I send you my surgery, because I know that I am not qualified to do it. But George is wild about the green stuff. He has always been in love with the lettuce leaves, and there is no cure for him or people like him. I advise you to leave him alone. You will never jolt him. He plays poker Saturday nights with three of the Hospital Trustees, and he is a deacon in the Sabbath church. This gives him power, and he has enough to ruin you.

"You may have heard about Dr. Tom who came here several years ago; matter of fact, he was from your hospital, and a good man. We needed him in Fairhaven. Tom got the evangelical spirit and began to spread the gospel according to the American College of Surgeons—standards, fees, and all the rest of it—and at every turn he ran smack into George. You know that a surgeon has complications, and Tom had a few, not his fault, mind you. George began the whispering campaign, a soft breeze at first, but a whirlwind before he finished. It was about the inexperience of Tom, and he would have to make a few mistakes to learn, but wasn't it too bad he lost the Jones kid who might have been saved. Tom's springs began to dry up, and when George had done his job, Tom was through in Fairhaven. Let me warn you, George can do it to you, too. He is poison when he is attacked. Leave him alone. Work with him, keep your own record clean, but don't attack him."

Jo did some more thinking and came up with some

conclusions. It was not fee-splitting that was The Evil, for this was only a symptom of a widespread disease. What one was trying to eliminate was racketeering, or payment to doctors for services that they had never rendered to a patient. But what was a fair fee? A G.P. who stayed up all night treating a case with coronary thrombosis had certainly done a greater service than a surgeon who removed a negative appendix. But the G.P. could not possibly charge \$100.00 for his services without being considered exorbitant; while the surgeon was thought to be most reasonable by sending a bill for only \$100.00.

It all came down to a matter of each man making peace with his own conscience. But consciences came in all sizes and shapes. Some were sensitive and responded to a light stimulus; others were lethargic and stirred only when disturbances were intense. A dull conscience might be developed into a finer instrument by persuasion and good example, but not possibly by legislation. Mankind had been legislating for centuries against immorality, excess and abuse, but with questionable success, for there was still a lot of it around.

What to do? This exchange with Frank solved no problems, but merely pointed up the difficulties, the justifications for obvious misdeeds. Jo was tired, tired of work and the never-ending conflicts that surrounded him. When he walked through the front door on Friday evening, he fairly collapsed. Alice sat on the arm of his chair, and said in an off-hand manner, "Let's relax over a drink, dear."

"I'm on call tonight."

"Oh, forget the 'on call'!"

"For heaven's sake, dear, I have all of these sick people . . ."

"Yes, and you've got me. What I'm trying to say is that there is still a chance. You have stopped climbing. You're groveling, scratching in the dust. I want you to fly, to soar above this herd of the ordinary. We came to Fairhaven to live and be free. They've got you shackled. You're chained to a steel ball. I know the symptoms. You come home and stare at the ceiling. You haven't spoken a kind word to the children for weeks. We're off. Pack your bags. Mine are ready."

His father and mother had retired to a small property in New Pomfret where they tended chickens and milked a few cows. There was a guest room with bath for tourists, relatives or acquaintances if they showed up.

Jo and his dad had settled down to cigars after the evening meal. Alice and his mother were out in the kitchen doing the dishes. Jo began quietly enough, telling about his problems in Fairhaven, and his father listened for a time. He interrupted Jo rather abruptly and said, "This fee-splitting you speak of, Jo, isn't a legal wrong is it?"

"What do you mean, dad?"

"Well, a fellow can't be put in jail for fee-splitting, can he? After all, it is a common practice in commerce to pay rebates and discounts, and no one is ever prose-

cuted for such practices. I believe that lawyers have something called a forwarding fee, although I am not quite certain what that is. Fee-splitting relates to an ethical principle." He hesitated for a moment. "It is essentially a moral problem, no?"

"Yes, I suppose it is," said Jo.

"Why not approach it as a moral issue? There are no such things as absolute morals, you know."

"Well, dad, I can't say that I had thought of it that way."

"Take as an example my early childhood. I was brought up rather strictly. In our home my father and mother believed and taught us that all cards were instruments of the devil and dancing was a trap set by Lucifer to snare the unsuspecting. That made it morally wrong for me to dance and play cards. But many of my friends were brought up with a different set of values, and they did these things with quite a clear conscience. Do you see what I mean? Morals are relative to principles adopted from church, home, school and associates."

Jo hesitated for a long time and then he looked at his father sharply before exclaiming, "I know what you are going to say, dad, I know. It's a bit of slippery sophistry."

His father took a few deep puffs of his cigar and continued in his slow, drawn speech without a sign of emotion. "Everyone has a somewhat different moral code, because of the influences in his life. Has it occurred to you that some doctors may have been conditioned by association and experience to believe sincerely that fee-splitting is right, morally correct?"

"Oh come, dad. This package I will not buy."

"I am only taking the approach through fundamentals, the fundamentals of all morality."

"Well, I won't buy it, but go on."

"For you, Jo, fee-splitting is wrong, and so you must use every means in your power to stop it. But morality is not generated by force. It grows under the influence of persuasion and good example. Let me ask you a question. If a man is inclined to split fees and believes that it is right to do so, is there really any way that you can stop him, money being such an elusive commodity. You may drive him underground, but can you stop him?"

"That's what makes me burn. You can't," said Jo. "There are these equivalents of fee-splitting, all sorts of practices by which an unscrupulous doctor gets paid for services that he has never rendered to a patient."

"Exactly. It seems to me that your medical societies have been preaching against fee-splitting as long as I can remember. Doctors have signed pledges and are threatened by expulsion if they do it, and what has been the result? I read a statement by a fellow named Hawley, a responsible man, I believe, head of the Surgical College or something. He said that fee-splitting was more prevalent than ever. Why? Because an increasing number of doctors do not consider it morally wrong."

"Dad, I never knew you to be given to double-talk. Here you are justifying evil because it exists."

"Oh now, I'm not that senile. Do you remember Prohibition? Perhaps not much of it. People violated the law of the land in numbers beyond count. Millions drank. Why? Because they did not consider it wrong to do so."

"But did that make it right?" asked Jo.

"Now you have asked a question which even the best philosophers have never answered. We could pursue that argument all night. For our purposes, it does not matter whether it is right or wrong. What you are setting out to do in this campaign is not to punish offenders but to change their point of view. The most important consideration is that you can do little or nothing about bad morals unless you convince a man that they are bad, and that brings me down to your immediate problem. If fee-splitting and all of its equivalents, as you call them, are wrong, then a man ought to be better off in the long run by not doing them."

"Virtue is its own reward, that sort of thing?"

"No, not at all. You ought to be able to show George that you can make more money than he by adhering rigidly to your code of ethics. Then you can take him aside, oh, it may be five or ten years from now, and say, 'You see, it isn't necessary to do this shady business to make money.' It must be true generally that one can make more money by trying to get people well than by trying to make money. When you adopt this line, people will trust and respect you, and a professional man's only stock in trade is his reputation."

"Let's get down to specifics. What would you do if you were me?"

"I am always suspicious of a moralist who shouts from the housetops. He may be barking only to cover up his own misdeeds. You have a sound moral code, Jo. Stick to it. Make your conscience your guide. You need not try to reform the medical profession. Over the years you may or may not convince George, but you will set an example for any young men coming to Fairhaven, and so you will have been an influence for good. What more can anyone ask of you?"

From then on Jo worried little about George. He met him in the locker room of the surgery, and as they were changing their clothes he exclaimed, laughing, "Rather a neat charge you made to Mrs. Wetherby. How do you do it, George? How do you dare?"

"Well, she paid me. That's all that counts. Charge them and collect. Hell, all these people know me. I'm in it for the dough. I want my dough, see. Trouble with you is that you're not a business man. I'm going to make my pile and retire, and you'll still be frittering away your time doing all this fancy surgery when you are 65."

Yes, his dad was right. Changing George would be difficult, maybe impossible. He would try, but now it seemed to be a matter of little importance. It was to the new generation that he would give his undivided attention. George was the past, and Jo was looking into the future.

Financing a Medical School

Sir Lionel Whitby, M.D., F.R.C.P.

REGIUS PROFESSOR OF PHYSIC IN THE UNIVERSITY OF CAMBRIDGE

When an Englishman has had the privilege of being associated at any time with the Peter Bent Brigham Hospital or with some other institution which is part of the Harvard Medical School, he afterwards enjoys certain great advantages. One such privilege is that he receives some of the literature about the school. Consequently, I have had the interest, stimulation and instruction which must naturally come to anyone who has read Dean George Berry's paper on the financing of the Harvard Medical School. So greatly has my interest been aroused that I make bold to offer a few comments, some of which contrast the English and American systems of the present day, and which may therefore sometimes describe a different line of approach to a common problem and a common



Sir Lionel Whitby

ideal. The differences are, on the whole, dictated by expediency rather than choice.

It is, in the first place, very obvious that the primary problem is the same in both England and America, namely, money. It is also clear that there is neither end nor final solution to the problem. The cost of medical education will never decline; the more complex the science of medicine becomes, the smaller the groups of students that have to be taught, if teaching is to remain efficient, and consequently the greater the number of the teachers. Unhappily, all the present-day great advances in medicine, with their costly impact upon medical education, are occurring at a time when, as Dean Berry says,

there is "a devastating effect of dollar inflation upon such activities as ours," and he speaks of "the growing complexity of the teaching enterprise in modern medicine."

Dean Berry is a realist. He has no hesitation in saying that "the purchasing power of the dollar has been halved in the last fifteen years," and, in order to bring this home, he makes use of an ingenious "calorie-dollar" standard of reference, which shows that, whereas there has been a twenty-fold increase in the necessary expenditure of the Medical School, the income available has provided only a seven-fold increase in ability to buy what the dollar must buy. This lays bare, in a realistic manner, the degree of inflation which has occurred, and answers all the arguments of the amateur economist, who might be complacent about the budget of a medical school, thinking only in terms of apparent, rather than real, figures.

If this is the case in America—and I believe it is so—which is the richest country in the world, how much more does it apply to a country like England, formerly rich, but now living under the burden of two wars, and in an incomprehensible (to the layman) complex of hard and soft money exchanges. This, in fact, is one of the reasons why I have taken up my pen to make comments, because some account of the manner in which a relatively poor country,

Editor's note: It was the Editor's privilege to spend a year of post-graduate study as a fellow of Downing College, Cambridge University. At that time Sir Lionel Whitby was Master of Downing College and Vice Chancellor of the University. In November, 1946, he spent a week as Physician-in-Chief *pro-tempore* at the Peter Bent Brigham Hospital and renewed his acquaintance with Harvard during a brief visit to the Brigham in 1954. Without sponsoring a particular argument in the accompanying article, he clearly and tactfully contrasts the British and American systems of financing medical education. His concluding paragraphs pose questions of grave and immediate importance not only for Harvard but for all medical educators in the United States.

but one which is nevertheless rightly and properly proud of its long medical tradition, has approached these problems may perhaps give food for thought in a country which has never hitherto been subjected to stringency.

Let me first take certain points from Dean Berry's survey. He estimates that, to raise the salaries of the staff of the Medical School by about 10 per cent, in order to go some way towards meeting the increasing cost of living, would require an additional \$140,000 annually. He estimates that the Medical library,—the heart of the Medical School—the use of which has quadrupled in a decade, needs an endowment of five million dollars in order to meet operating costs. The Dean's plea is for money to repair the traditional financial structure of the school, and he makes the point that to offset the deficiencies, the school must find new "unrestricted" money, or otherwise face the prospect of having their ambitions and enterprise undermined. He gives a revealing survey of how the increased income of the present day has been derived. First, from endowment; secondly, from tuition fees; and thirdly, from money provided to support research. All these sources of income have apparently increased during a decade. Endowment income, for example, has increased by 66 per cent, but this is only a real increase of some 11 per cent on the Dean's calorie scale. The income from tuition fees has likewise increased by 9 per cent. It is noteworthy, perhaps sinister, that outside sources of income, mainly restricted to research, have increased by 150 per cent. Dean Berry, however, is of the opinion that the support which industry gives to medical education (or research) is less than it should be in view of the contributions medicine has made towards a most flourishing industrialized society. He also points out a fact which medical schools have been slow to realize, namely, that the overhead charges made to sponsoring bodies need to be increased, since they rarely cover an economic portion of attendants' wages, gas, light,

water, telephone, etc. Much sponsored research has, hitherto, cost medical schools a good deal of money, though this has not been apparent. The great increase in income from commercial sources would seem to imply that the School is tending to lay more stress upon research than upon teaching. One might also comment that such monies supply a fluctuating income liable to be earmarked and restricted to certain fields of research. This kind of income is not one which can be greatly used to fulfill one of the prime duties of a University, namely, the duty of teaching.

The Statutes of the ancient University of Cambridge, England, state that the University is "designed as a place to promote education, religion, learning, and research." It is, of course, sometimes difficult to separate education, learning and research into water-tight compartments, but there is no doubt that it is fundamentally important to preserve a balance between the three. No one would question that good teaching cannot be carried out without having departments, teams or individuals who are actively engaged in research, and who are concerned in tending the growing points in medicine. There is, however, something to be said for entrusting much of the sponsoring of such work to impartial and financially disinterested organizations, such as the Medical Research Council, which exists in England, and the National Research Council in America. Moreover, none can deny that a commercial firm must eventually have its eye upon the dividends of its shareholders. The money which the firm subscribes will be expected to yield results which a hard-headed and realistic Board of Directors will analyse, if not immediately, at any rate, in the long term. These comments are open to the criticism of cynicism, but there is little doubt that financial support of this kind is greatly dependent upon commercial prosperity and the tax laws. In Britain, the number of projects financed from such sources is very much less than

it is in America. One need say no more than that if a wave of depression happened to strike America, this source of income for a medical school might be greatly reduced.

Dean Berry himself makes the point that what the school really needs is income for recurrent needs, whereas money derived from outside sources is usually given for current purposes and short-term projects. This outside money, he says, may indeed be vital for bringing to fruition the school's total enterprise, but, on the other hand, it may play havoc with the other duties and requirements of the school, most of which are recurrent. His plea is for income for general purposes ("hard money") necessary for security and continuity. The amount required, however, can never be stabilized, so long as inflation continues, and so long as medicine advances. The cost of operating a school nowadays is almost incredible, and in it the wage spiral and the inevitable cost of such sections as the library are inestimable for more than a few years ahead.

It is notable from the Dean's report that, as elsewhere, the wage increases of technicians and of staff are running ahead of increases in professional salaries. Dean Berry's main hope for increased income lies in the generous gifts of Alumni and other friends. These unrestricted gifts are of immense value and are, indeed, impressive to an Englishman, since this old country has almost passed the phase when such gifts, or gifts of a magnitude sufficient to have a material influence, are still possible. It is heartening to one from the older generation to learn that donations from individuals to the Harvard Medical School, that is, gifts from the Alumni which are entirely unrestricted, have increased from three per cent to 11 per cent. It is, however, very hard work to sustain a regular income from such sources.

This is perhaps one of the first points on which I might make a contrasting comment. In England the gifts of the alumni, relatively few in number, are largely confined to the endowment of prizes or scholarships,

perhaps named prizes, or named scholarships, but they are rarely, if ever, given as a contribution to the general income of the School. To me, it was a great surprise to learn that the students' liabilities in a year—presumably including subsistence—might amount to as much as \$2,500. The tuition fee of approximately \$1,000 is at least four times the tuition fee of a medical student in England, and most English students would expect to accomplish their medical training on an income of not more than \$1,500 a year. It is therefore little wonder that, in America, there is such a great need for scholarships and loans, in order to finance the student through his career. One might comment that if so much money has to be invested in advance, it is to be hoped that all those in whom the money is invested are worthy of the trust. Selection must be a highly important matter. It is pertinent (even if not tactful) to ask the question as to whether it is really the duty of the Alumni to pay for the medical education of future generations?

At one time in England, and in America alike, the entire cost of a student's education was borne by his parents, but often this is no longer possible. In England, this cost is now borne to some extent by scholarships which supplement the parental allowance, or by grants from local and county authorities or the State Board of Education, in the case of students who have shown that they are worthy of such support from public money. In Harvard, the student would appear to have somehow to find the means to support himself, either from his parents or from scholarships, or from loans.

As for the running expenses of the school itself, the salaries of the professors, the lecturers, and the administrative staff, these, in America, appear to be the private concern of the Medical School itself, which has to obtain a sufficient income from one of the three sources which I have mentioned above. In England, we took a step forward a number of years ago, when we agreed to accept money from the Government for all types of education in Universities, but interposed between the University and the Government the body known as the University Grants Committee, whose function it is to scrutinize the proposals and budgets of all Universities. Thereafter the University Grants Committee recommends the allocation of an appropriate block grant from Treasury sources to cover approved expenditure in Universities, without in any way interfering with their autonomy.

Britain has had to realize that the individual can no longer bear all of the cost of education, especially since the benefits of education have been made available to all who are worthy, irrespective of wealth or social grade. The State, in its turn, has realized the responsibility which it holds for the education of the growing generation, and with typical British compromise, a reasonable kind of structure has been erected, in order to prevent the State from interfering with the liberty of the individual, which is so dear to the heart of every Englishman.

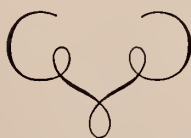
As for Research: there is no doubt that sponsorship by commercial houses is very much more extensive in America than it is in England, and that, consequently, in the former

country, the research programmes are more ambitious and spacious. In both countries, research is fostered by the Foundations and Funds. In both also the State-financed Research Councils play a great part, but one gets the impression that the Medical Research Council in England is much closer to the Medical Schools and the young research worker than is the National Research Council in America.

I send these notes and contrasts with neither criticism nor advocacy of the system of either country, but merely to show that one part of the world may not know how another part lives, or has to live. This is particularly interesting in two countries such as Britain and the United States which have so much in common, of which much is, in fact, common heritage.

From a realistic angle, one can summarize by saying that the American system is dependent upon private and commercial wealth, as was the case in Britain for at least 300 years. The British system now rests upon the prosperity of the country as a whole, rather than that of the private individual. So long as the country remains solvent, so long will medical education and medical schools and medical research continue.

If prosperity increases, the scope of all will increase; if it declines, retrenchment will be necessary. Will America come to the same point of view? Will Harvard find, one day, that it can no longer finance the immense cost of medical education and research from the three individual sources from which, at present, it derives most of its income? It is not for me to say.



C. P. CEAMANSHIP

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Stephen Potter¹ has contributed greatly to man's survival by describing the technique of "One Upmanship." Bulfinch² was the first to apply the Potter principle to medical problems and recorded his observations in the Harvard Medical Alumni BULLETIN in a classic article entitled "Roundsmanship" which describes "housemanship" and points out the subtle interplay that makes the medical man's life fascinating. Dimond³ has pointed out the interplay that exists between the medical audience and the medical speaker. His case reports give him just reason for formulating the ground rules for an audience, since they illustrate the technique of "hostmanship" used by several medical groups in their endeavors to crucify a speaker.

I have been interested in the interplay that exists between the clinician and the pathologist at the teaching session known as the Clinical Pathological Conference (C.P.C.). This interplay is termed C. P. Ceamanship. The purpose of this report is to point out the salient features of this type of "One Upmanship."

Definition of C. P. Ceamanship

It is generally accepted that there is considerable interplay between the clinician and the pathologist. The Clinical Pathological Conference is the arena where all pent-up antagonistic emotions reach their summit. The conduct of the members at this conference can be termed "C. P. Ceamanship." (The initial C. P. is important since this clearly separates the subject under discussion from simple Ceamanship. The latter ap-

plies to the conduct of members of any conference, medical or non-medical.)

The clinician should feel the weight of all clinicians on his shoulders in his stand against *all* pathologists. Accordingly, the tension should be high. He must, if possible, make a correct diagnosis. There are, however, techniques available that enable the clinician to miss the diagnosis but leave the audience and pathologist so confused that no one really knows what the clinician thought. The good C. P. Ceaman uses these techniques 75 per cent of the time. If the diagnosis is missed, then he must be ready at all times to interject the thought that "from a teaching standpoint, it is better to miss the diagnosis since those in attendance had the opportunity of hearing about two or three other subjects in addition to the discussion of the real problem."

The object of the pathologist is to make a "knuckle-head" out of the clinician. With proper training he is able to indicate that he had hoped the clinician would discuss other facets of the problem, and thereby is able to detract from a brilliant clinical diagnosis. There are many time-tested maneuvers utilized by the pathologist that force the clinician to leave the arena intellectually bleeding. After careful examination, I have counted nine large scars of my own.

Incidence of C. P. Ceamanship

The more subtle slanders that occur at the C.P.C. are often overlooked in the early years of attending such conferences. These initial "errors of insight" exist because it requires time to develop the frame of mind needed to make such observa-

tions. The frame of mind can be described as being receptive of subtle sarcasm while simultaneously observing the angelic expressions of the medical masters. After one learns what to look for and adopts the proper frame of mind, the incidence of C. P. Ceamanship seems high, and in 10.241 per cent of conferences reaches epidemic proportions. This is known as the domino reaction. Under such circumstances there is a chain reaction among the whole medical staff or pathology staff with each member tossing a terse barb at the opposing group.

Classification of C. P. Ceamanship

It should be stated at this time that there are several groups of subgroups of the practitioners of C. P. Ceamanship. Space will not permit a complete classification, but there seems to be a spectrum of characters, all with different techniques, ranging from the quiet, humble, apparently dignified gentleman who utilizes his henchmen to execute a carefully preconceived plan of operation that totally destroys his opponent, to the outspoken expert who cuts down the opposition with ad libs that are not ad libs. (Some will see the need of a more elaborate classification which includes Ceaman 1st Class, Ceaman 2nd Class, and Ceaman 3rd Class, but since it is my object to simplify a complicated subject I prefer not to use this classification.)

The Salient Features of

C. P. Ceamanship

The characteristics of C. P. Ceamanship can be conveniently divided into (1) C. P. Ceamanship from the clinician's point of view, and (2) C. P. Ceamanship from the pathologist's viewpoint.

- (1) C. P. Ceamanship from the clinician's viewpoint

Editor's note: Dr. Hurst was a Teaching Fellow in Medicine in Harvard Medical School in 1948-49.



Clues from the Librarian

(a) Comments on not receiving the manuscript

The manuscript describing the history, physical exam and laboratory work is usually sent out several days prior to the date of the Clinical Pathological Conference. An initial blow can be dealt by the clinician if he telephones or visits the pathology department the afternoon prior to the battle and states with desperation, "Whenever will I receive my copy of the protocol? I had hoped to look up something about the case but since I have not received my copy I will try to discuss the case without any preparation." Some pathologists know by now that you already have a manuscript and that this really means you are ready for bear. Other pathologists, unacquainted with one upmanship, become quite concerned, chew out subordinates and begin to worry about the whole conference. It is a grand blow when the clinician can approach the head of the pathology department regarding the problem of "no manuscript." The chief pathologist becomes emotionally disturbed and almost disoriented when he can't find any of the copies of the protocol. (The secretary in charge of manuscripts will be gone if the clinician times his visit properly.) Another clinical blow can be dealt the night before the conference if the clinician calls the pathologist and tells him he simply cannot read the mimeographed manuscript because the words are blurred.

(b) Preparing the discussion

Having received the manuscript on time, although unknown to the

pathologist, the clinician studies the material and tries to come to a logical diagnosis. He then goes to the library and checks out the books that should help him. While in the library he may be able to find a stack of books checked out by the pathologist. The titles of the books may give a real clue to the diagnosis. Occasionally small slips of paper identify case reports in the books that are definitely *apropos*.

It is considered good C. P. Ceamanship to prepare two different discussions. One discussion leads to a clear-cut diagnosis. The other discussion is peppered with impressive medical gems but does not lead to a clear-cut diagnosis. The fact that the diagnosis was not made can be concealed by utilizing a technique to be described later. The preparation of two discussions is time-consuming but is distinctly worthwhile since it allows the clinician to take advantage of any last minute information that might cause him to switch to the opposite diagnosis.

Ad libs must be prepared in advance and appropriate props and teaching aids must be utilized whenever possible (i.e. crystal balls, magicians, wands, etc.).

(c) Approaching the speakers' platform

This is an important facet of good C. P. Ceamanship. The clinician must approach the podium with a completely blank expression. If a mild, restrained fright can be exhibited, so much the better. He should not *look like* an expert. A later article will deal with how to know the diagnosis and yet look as though you do not. This phase of C. P. Ceamanship is governed by experience and hard work.

(d) Reading the manuscript

The protocol should be read slowly. It is read slowly in order to have time to grumble about the blurred words, comment on the obvious errors, such as the routine order that Mrs. Jones was allowed to stand by the bedside in order to void, etc., etc. There is only one exception to the rule of slow reading. The

clinician must mumble rapidly at least once during the reading in order to indicate that too much unimportant yak-yak has been added to the work-up. The clinician should always ask for several bits of information not given in the protocol. With the proper facial expression, such a request can shake the pathologist to the shoes and force him to review the clinical chart again and again. At this point it is useful to say, "Surely you have not withheld any other vital clinical information?"

(e) The pause before the discussion

It is important for the clinician to pause just before the discussion in order to survey the battlefield. How many slides does the pathologist have? A large number of slides indicates a diffuse process whereas only one slide would make such a possibility unlikely since one can usually count strongly on the innate desire of the pathologist to show as many slides as possible. Is there a member of the pathologists present who is considered to be the local expert in Lollapolooza? If he is present, the clinician has it made.

(f) The clinician's discussion

The clinician must start with a comment regarding how difficult the case is and how difficult the care of the patient must have been if there was no more information than given in the protocol. The clinician is then in the position to state that it



"... approach the podium with a completely blank expression ..."



"... a maze of chit-chat and guff ..."

will certainly be wonderful to get a clear-cut diagnosis from the pathologist. This statement will really make you one up if the pathologist cannot make a diagnosis. (Which is often the case.)

Perhaps the most useful technique possessed by the clinician is that of giving a good discussion without giving a diagnosis. For example, if a patient complained of chest pain, the clinician should discuss *all* diseases causing chest pain. He then has at least mentioned the correct diagnosis. He should watch the pathologist's face for clues as he begins to discuss each new disease. It is more rewarding, however, to note when the pathologist first looks at his watch. I have found that if you talk exactly three minutes and 14 seconds past his initial glance at the watch, he is so impatient to begin his prepared rebuttal that he does not notice that a final diagnosis has not been made. (This time interval varies to some degree with the locale and must be determined after careful study of the individual pathologist.)

Occasionally it is useful to give

two diagnoses. One should be termed the "C. P. C. diagnosis" and it is here that the clinician indicates that the pathologist seeks rare diseases to discuss at such conferences and that he does not understand the practical side of medicine. The other diagnosis is the "reasonable diagnosis" based on the available data.

(g) Case report

I once had the opportunity of being one up on the pathologist. I really was a little "one up," but I am still disappointed that the "up" was not bigger. As a cardiologist I seem to detect great glee in the pathologist's voice as he asks me to discuss a case of rare brain disease or some other disease that more often than not is outside the large field of internal medicine. I once was given a case of schistosomiasis of the brain. The diagnosis was really quite obvious but I anticipated a dull discussion on my part. I merely asked one of my friends, who just happened to be a neuro-surgeon, if he had ever seen a case of schistosomiasis of the brain. He proceeded to describe in great detail the same case given in my

C. P. C. protocol. My ears really perked up when he said the case was reported in a certain medical journal. When he gave me the patient's name and pointed out that the man recovered and was living in a nearby town, many new thoughts came to mind. I tried desperately to reach the patient on the telephone to invite him to come to the hospital at my expense and be ready to step into the C. P. C. room at the proper cue. Unfortunately I could not reach him and missed the opportunity of being one up. I was a little "one up" when, at the conference, I stated that I had lost my protocol and after refusing to accept a new one from the pathologist proceeded to read the case report from the medical journal where it was reported.

(2) C. P. C. Camanship from the pathologist's viewpoint

(a) Comments on preparing the manuscript

It requires many years for most to learn to write a really confusing C. P. C. protocol; however, with proper instructions a respectably ambiguous manuscript can be turned out by the beginner. The basic objective should always be kept in mind, that is, to balloon up every unimportant detail in order to bury the important points in the maze of chit-chat and guff. For example, if a patient had heart failure, the patient's headache, genito-urinary complaints, and emotional problems should be discussed *ad nauseam*, but very little should be said regarding dyspnea or edema.

(b) Comments on sending out the manuscript

The manuscript should not be sent out the week before the conference since that would be too convenient for the clinician. The manuscript cannot be sent out one day before the conference for this would enable the clinician to make derogatory remarks regarding promptness. The manuscript must be sent out two months in advance in order to obviate any possibility of comments regarding promptness. Occasionally the clinician will not recall the day of the conference since so much

time has passed since he received the manuscript. The pathologist can then telephone him the afternoon before the conference, or, better still, the morning of the conference to remind him of his obligation. This assures the pathologist that he can actually have a conference and also makes him one up when he detects the anxious note in the clinician's voice indicating panic due to his failure to recall the conference date.

(c) What the pathologist should do while the clinician has the floor

This aspect of C. P. Ceamanship should receive more attention. Available data indicate that more could be done in this area in 28.2 per cent of conferences. Information at hand indicates that the clinician can be confused to a varying degree if the pathologist will interrupt and ask in a kindly voice if the clinician will elaborate on certain clinical points that are made. By doing this at strategic points in the discussion, the clinician can be skillfully led by the nose away from the correct diagnosis.

General rules regarding the skillful breaking up of any conference apply here also. For example, the windows can be adjusted, phone calls can be made, etc. (The latter

is especially successful if the phone is in the conference room.)

(d) The interplay before the pathologist's discussion

If medical students are present, the opportunity frequently arises that allows the pathologist to be one up in a big way. A pathologist must collect the student diagnoses on slips of paper. If no students make the correct diagnosis, then the whole affair should be quietly neglected. If, on the other hand, several students make the correct diagnosis and the clinician has not, then much time should be spent finding out how the diagnosis was made. When the students explain their reasoning it will be clear and simple. This situation exists frequently and can be termed "how to be one up in a round-about way."

(e) The pathologist's discussion

The pathologist must also prepare two discussions. This is vital in good C. P. Ceamanship. If the clinician misses the diagnosis, then the pathologist can give the accurate diagnosis in his opening sentence, using such phrases as "straight-forward," "ordinary" and "garden variety" to describe the condition that was so obvious. If the clinician makes the correct diagnosis, then the pathologist uses discussion number two. In

this discussion the skin is described and the physical findings that are not recorded on the clinical chart are emphasized, especially if they have nothing to do with the case. The microscopic slides are then described in great detail. The material that relates to the real problem is saved until last and is covered hurriedly at the end of the hour. All of this detracts from the brilliant clinical diagnosis and leaves the impression that it is of little value to discuss anything so obvious.

As a clinician I once received the triple barrel treatment. This technique employs the simultaneous use of several pathologists. After predicting nine out of ten facets of a complicated problem, the one facet not covered was pounced upon. Three new pathologists arose on cue and marched to the blackboard where they proceeded to illustrate the various steps leading to the development of that particular part of the problem. As I started to rebutt I faced four pathologists and accordingly accepted the "one down" state as gracefully as possible.

Summary

The interplay that occurs between the clinician and pathologist at the Clinical Pathological Conference has been discussed. The conduct of the members of the conference is called C. P. Ceamanship.

The techniques utilized by the clinician and by the pathologist in their efforts to be "one up" have been discussed for the first time.

Expert C. P. Ceamanship makes for an exceedingly interesting conference. There are few sleepers in the arena and what is said there is difficult to forget (or forgive).

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"I faced four pathologists . . ."

Editorial

THE PATIENT'S PATHWAY

Specialization in surgery has created an intricate network of pathways of referral of patients to specialists. These pathways may originate with other patients, friends, or practitioners. It is of interest to speculate on the influences which direct them.

When the pathway starts with a former patient it is directed toward the author of a previous favorable surgical experience. When it starts with a personal friend or acquaintance its direction may be the result of confidence in a strong personality. When it begins with another doctor recognition of professional merit in the specialist should always be, and usually is the motivating force. This is the patient's pathway. Unfortunately, however, this motive is not invariably the sole influence determining referral. Mercenary motives creep in, fee-splitting is practiced, and the doctor's pathway replaces the patient's pathway.

Consider the sequence of events which leads to fee-splitting. For it to exist there must be a fee large enough to split. Such is the case in the surgical field where the climacteric nature of an operation renders the patient willing to pay, or even desirous of paying highly for "the best." Parenthetically speaking, high fees may cause troubles other than fee-splitting. They render the young surgeon willing to wait for years after he has reached the peak of his training before gaining access to a surgical practice large enough to realize his potential. They create a temptation, not always resisted, for those inadequately trained, or not trained at all, in surgery to perform surgical operations. And, conditioned by ignorance or a self-deceptive dishonesty, they are the sources of the much discussed problem of "unnecessary surgery."

Attempts are often mistakenly made to define the wrong which is fee-splitting by the fact that the patient is thereby made unaware of what part of his money goes to which doctor. As if the patient really cared! What is more fundamentally wrong is that it tampers with the patient's pathway. The fact that the patient may get less than optimal treatment because the surgeon pays another doctor for referring the patient is surely more undesirable than that the patient does not know how his money is divided between doctors.

Is the solution, then, the lowering of surgical fees? Although extortionary abuses occur and should be eliminated, they represent a different problem from that of lowering all surgical fees to below a point where the temptation to fee-split would no longer exist. The size of fees is in the end based on the market, and that is created by the consumer. If surgeons were put on an hourly wage, for instance, a black market in surgery, demanded by the patients, would undoubtedly arise.

If a patient is willing to reward a surgeon handsomely, this should only strengthen the latter's resolve not to tamper with the proper working of the patient's pathway of referral. How best a young surgeon may understand and manage his conscience in the face of the varying degrees of tampering that may occur in this or any community has been set forth by Lium in this issue. His thoughtful and vivid presentation of the matter will help many of us to think more clearly on the problem.

R. W.

R.S.V.P.

By the time you read this, the Fourth Annual Fund Report will be in your hands. We have a particular reason to hope that you will read this carefully before consigning it to the commodious wastebasket which a doctor needs nowadays. In four years, the Fund has raised a considerable amount of money, and it is conceivable that we will never increase the amount of annual contributions. It seems to us that the percentage of donors is much too small. Perhaps we are wrong. However, serious doubt exists as to our being anywhere near the saturation point. Doctors are reputed to be poor businessmen. Perhaps this is so. The Class Agents were selected for a number of favorable reasons, none of which had to do with their ability as fund raisers. It is possible that the whole drive should be put in the hands of a professional fund-raising agency, for a fee. We do not believe so. After you have read this report, we hope that every Alumnus as well as every Class Agent will consider the reasons for not contributing, or for not contributing more. It is important to separate the rationalizations from the reasons. We would very much like to hear the thoughts of the Alumni on this subject, whether critical or not, but Harvard indifference will not serve the best needs of the Medical School.

C. P.

Thoracic Surgery in India

Reeve H. Betts, '33

No doubt the question that comes to the minds of most of you is "Why go to India to practice thoracic surgery?" There are many valid reasons, but the most compelling to me was my inclination from the time I started college to become a medical missionary, although I had no particular leaning toward India. It did not appear as if things would work out that way, however. During my fourth year in Medical School as I became more and more interested in thoracic surgery, it seemed totally illogical to think of going into thoracic surgery and still expect to be a medical missionary, as the two seemed completely incompatible. One must remember that the year our class graduated from Harvard Medical School was the same year that Dr. Evarts Graham performed the first successful pneumonectomy for carcinoma of the lung! Thoracic surgery was still to become a specialty. The opportunities for the practice of thoracic surgery in the United States seemed limited indeed during those years and therefore the hope of doing thoracic surgery in a mission hospital was simply unattainable. It is a common belief, though, that things will work out if one is persistent enough, and those with a more religious approach believe that God will provide the way.

Securing adequate thoracic surgical training was not easy twenty years ago, as so few centers had specialized departments where material was concentrated, and I have always been thankful for the ten years of inspiring and happy association with Dr. Richard Overholt, both at the Lahey Clinic and later in private practice. Various things, mostly World War II, prevented imple-

menting my earlier resolution until the post-war period. After two and one-half years outside the U.S. and away from my family I thought I might not want to leave the U.S. again, but I found that I still was not completely satisfied and knew I never would be unless I followed my earlier plan.

Even so, in 1947 there was no place in the world that I knew of where one could do any amount of thoracic surgery in a mission institution. Both Martha, my wife, and I believed it would not be right to go somewhere unless I could do thoracic surgery, as I did not think my training fitted me for anything else. As we were talking over various possibilities, I noted in the *J.A.M.A.* a note from the Christian Medical Council for Overseas Work that the Christian Medical College in Vellore, South India, needed the services of a thoracic surgeon! You can call it coincidence or Providence as you wish. Then followed 18 months of inquiries, plans and delays, including chicken pox and mumps which our young brood of three started taking in alternate doses just before sailing time, which had to be postponed by a month until each child could have his turn at each disease. But late March, 1948, after five weeks on a freighter, found us in this town in South India about 90 miles from Madras. Vellore is 13° above the equator and therefore about the same latitude as the Panama Canal, only our climate is very dry except during the six-week monsoon season, which sometimes comes and more often does not.

India is a land one-half the size of the United States with over twice the population. Poverty is extreme, semi-starvation is normal, and medi-

cal care is inadequate in the larger cities and absent in most of the smaller communities, although 85 per cent of the people live in villages. If one includes Pakistan, this sub-continent has over 400 million people or one-fifth of the world's population.

Medically the problems are stupendous. Malaria is still said to be the most frequent killer, but that will soon be changed if it hasn't been already, as the prevention of this disease as well as its treatment are so much simpler than those for some other diseases. Vital statistics are not accurate, but according to the best estimates there are over 500,000 deaths a year from tuberculosis. In the U.S. it is assumed that there should be ten beds provided for each annual death. On that basis, India should have five million beds for tuberculosis alone, compared with the approximate 10,000 she now has! The situation is similar, if not so drastic, in other conditions. India cannot afford large scale programs to alleviate such conditions as she is relatively a poor country and the total national budget is something less than one billion dollars annually.

On the whole, medical practice is very satisfying and rewarding here in India, as there are so many who need to be treated, and as a group they are very appreciative. What bothers is that you soon realize that no matter how many hours a day one works or how many beds you provide, it is simply physically impossible to take care of all those who need to be treated. Obviously the only alternative is to train more doctors so that they can multiply the facilities available. This is why we find our work in Vellore so worthwhile, as the college is now able to take 50 students

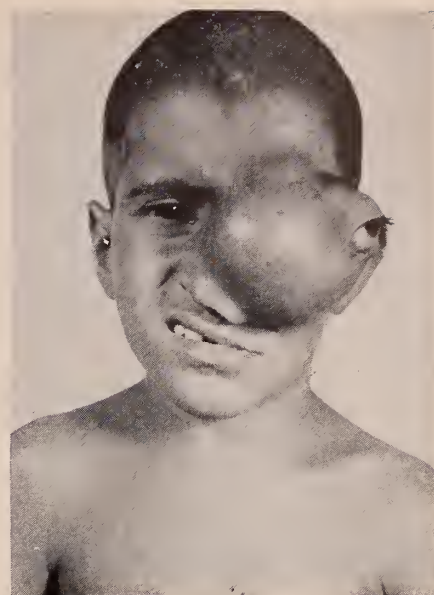
each year, half men and half women, and so each year more doctors are becoming available to meet the tremendous need.

In January, 1900, Dr. Ida S. Scudder, a graduate of Cornell and a relative of the famous orthopedic surgeon of the same name, came to Vellore and started a dispensary in one room of her father's bungalow. From this humble beginning has grown the Christian Medical College and Hospital, with over 600 beds. It is amazing that such rapid development has been possible and it is especially pleasing that Dr. Scudder has lived to see the fruit of her labors. She still lives here in India and at 84 is keenly interested in all that goes on although, of course, she is no longer able to take any active part in the affairs of the College except through her charming influence and presence.

The basic medical plan in India is the government medical service which has certain resemblances to medical practice in the Army, in that in many respects each doctor is considered the same and therefore there has been little opportunity for, or recognition of, specialization. Also, medical education is on the English University system and under existing regulations, specified postgraduate degrees are necessary if one is to have a teaching position. There is reciprocity between England and India, but not between India and the United States; therefore, our American qualifications are not accepted except under certain conditions. One can easily understand the importance attached to postgraduate degrees over here when one's chances of advancement are dependent very largely upon them. When we first offered training in thoracic surgery with two years of general surgery as a prerequisite and two years in the specialty as the minimum, and without any degree or diploma to be awarded, it received a cool reception. It was about two years after our arrival before our first trainee was accepted. Since that time there has been no dearth of candidates. We have now been able to enlarge the service to 45

beds and there are 16 more ready for opening as soon as more operating time can be provided by the new operating room which is in the process of being built. Two men are taken each year for the two-year appointment, and this number may be increased to three a year with the opening of the additional beds. It is really a most gratifying experience, as many of you well know, to see these young doctors come along and take over the responsibility for the service, and some of them have now gone out and are running very commendable thoracic services of their own. Under the older, English system, the young surgeon apparently never expected to get any operating to do on his own until everyone older than he had died or retired. Thus, the American resident system has been quite new to them and they are amazed at being given responsibility both for ward work and in the operating room about as rapidly as they are willing to take it. I think the British have been blamed unfairly for a great deal, but I do believe that they did not delegate responsibility to the younger doctors as they should have.

I hardly knew what to expect in the way of conditions when we first came here, as I had thought there would be little if any bronchiectasis in such a warm, dry climate and that probably rheumatic fever would be unknown—a concept that got into a number of our older American textbooks. Both of these expectations have been found to be false. Bronchiectasis is seemingly as common as in the U.S., and rheumatic fever, although I doubt if it equals the incidence that it has in New England, is still quite prevalent. Lung abscesses are very much more common, at least from the surgical standpoint, than in the U.S., as the local population as a group have very poor dental hygiene and there is practically no dental care. Antibiotics are not available to the ordinary villager, and consequently many late cases come to the hospital after months and months of duration, and hence are beyond medical cure. They have



A young boy with a large benign bone tumor of the left orbit. In spite of marked displacement, there was still good vision in the left eye. The mass was removed by our neurosurgeon, Dr. Jacob Chandy, with preservation of vision.

proved to be our third most common indication for pulmonary resection. Tuberculosis is so common that one has to limit the number of cases that one admits or the service will become purely tubercular. We have tried to keep the number of tuberculosis cases to less than 50 per cent of the service. Thoracoplasties are done in quite a number of sanatoria in India and we admit only resection cases except for an occasional thoracoplasty case so that the boys on the service can become familiar with that type of treatment as well.

The infrequent occurrence of carcinoma of the lung has been surprising. Only about three per cent of our resections are for this disease. It is of great interest that although smoking is common, Indians do not as a rule smoke the American type of cigarette, but most commonly a beedi, which is really a very small cigar. Of even greater importance, though, I believe, is the fact that only a very small propor-

tion of the people are able to afford to smoke heavily. Carcinoma of the esophagus, on the other hand, appears to be quite common, much more so than that of the lung. Pulmonary hydatid disease is fairly frequent, and these large cysts, as long as they have not ruptured and become infected, can usually be extruded without rupture, and the large intrapulmonary space closes in without difficulty.

We have many of the rare, striking lesions that one always finds where medical care is inadequate, such as seen in some of the accompanying illustrations. Duodenal ulcer in this part of India, where the diet is almost exclusively a very highly seasoned polished rice with curry, is extremely common. Because of the poverty of the patients and the lack of education, it is very difficult to treat them by dietary methods, and hence operation has become more or less the rule. Gastrectomies are at least ten times more common in our hospital than appendectomies, as for some reason the latter is very uncommon and, strangely enough, when a case does come in it is almost always either one of our students or a member of the staff. I have no idea why this is so. Dr. Howard Somervell, now of our staff, has been in India as a missionary doctor since he came out from England originally in 1922 and 1924 on the famous Everest expeditions. Hans Finsterer says that Dr. Somervell is the only

man in the world who has come close to doing as many subtotal gastrectomies as he has! By far the larger part of these operations were carried out in a small mission hospital with only a male nurse as anesthetist and without the benefit of any intravenous fluids or blood transfusions!

Our other very common lesion is carcinoma of the cheek and jaw. Beetle chewing is almost universal and in itself does not seem to cause any damage other than discoloring the teeth. (Many newcomers have commented on the wide prevalence of tuberculosis due to the number of people they saw spitting blood on the street!) In this part of India, however, they add tobacco and a lime paste to the leaf and this combination appears to be a potent carcinogen. This same Dr. Somervell has personally operated on over 8,000 cancers of the cheek and jaw—and that's a lot of cancers of the jaw!

The climate on the plains is hot most of the year, with April and May the two worst months, so we take our vacation at that time, and as I write this we are up in the Palani Hills about 75 miles from the extreme southern tip of India but at an elevation of 7,500 feet, and it is like being in a different world. This is also the place where the missions cooperate in maintaining a school run on the American plan for all the missionary children, and there are some 225 in the school at present. When we come to the hills, the children come out of boarding and live at home with us. They get their long vacation from the last of October to the middle of January, and then they come down and live with us on the plains. The temperature is just right during the winter months. Up here in the hills there is plenty of rain and the countryside is lush and green. Also here we can play golf on the only golf course in the world with local ground rules for tigers. You get a free lift if your ball lands in a tiger's pug mark! It's not all idle boast either, as we saw two dead cows, killed by a tiger, near the tenth tee when we were here three years ago!



"Madura Foot", a combination of actinomycosis and pyogenic organisms affecting, in this case, a hand instead of the foot. Vellore is about 300 miles from the city of Madura from which the lesion gets its name.

There is no doubt truth in the old saying that "East is East and West is West," but I don't believe the next line from Kipling, that "neither the twain shall meet." Although there is no doubt that East and West are coming closer to each other quite rapidly, yet the distance seems great in many instances. Time is not so important out here. These old civilizations have been going on for thousands of years and changes have come slowly and most of the people see no reason to expect any rapid differences. They have a degree of patience that is simply unknown in the West. Except in a few instances, all the rock for the roads is crushed by rows upon rows of women sitting along the side of the road pounding away by the hour, day, week and month. Our meals are cooked over three little mud pots with an opening in one side through which the wood can be pushed. A few feet above this there is a stove pipe that manages to carry off a bit of the smoke! Why put up with such an arrangement? Because it is cheaper for one thing, and the cook prefers it, for another. To an American everything is done the hard way here primarily because the ordinary labor is so cheap, about 25 or 30 cents a day, that it is cheaper to use lots of manpower than to buy expensive appliances. It takes three



A newborn child with macroglossia. This appears to be a fairly common abnormality in India.

servants to run our household of five because everything is done by hand. It takes the cook three to four hours to do the shopping—the four miles by bus to the bazaar, go to the various stalls, as vegetables are in one section, canned goods in another, flour still somewhere else, and meat even farther away. If we are to have beef (we can get it in our area as there are enough Muslims among the population to butcher cows, which, of course, are sacred to the Hindus), that means going two miles in a different direction to another village. Then he wants to come home on the bus, the bus driver, who is Hindu, will not let him get on the bus if he has any beef. Therefore the cook goes and buys the meat, comes home on the bus, and then sends the gardener to fetch the meat on the bicycle. The cook won't ride the cycle himself as he has to maintain his station! Thus two men can easily spend most of a morning just getting the shopping done.

In India there are 17 or 18 languages with some 280 dialects. In our part of the country the language is Tamil. The word for snake in Tamil is *pumbu* and the word for good is *nulla*. But the word for the cobra (and we have had one in our garage, and one in the house) is *nullapumbu*, or good snake. That makes absolutely no sense to the Westerner. But if you ask why they call such a deadly snake a good snake, they will tell you that the snake's business is to be deadly and kill things; therefore, the more deadly the snake, the better the snake is—hence, *nullapumbu*! We can't agree with their logic, but one can see that there is some anyway.

Likewise we cannot understand all that Mr. Nehru has to say or all that he does, as there is simply no doubt that the Oriental can believe two things that to the Westerner are diametrically opposed, and see no inconsistency in the belief. Most of us would like to see Nehru take a more openly anti-Communist stand, and yet I have no hesitancy in stating that he is undoubtedly strongly anti-Communist in his belief. Many

people here, including the well-educated, some of whom have spent several years in America, feel very strongly that it is foolish for India to arm herself against Communism or to join herself to the Western block which would automatically provide more military protection. It is their belief that if India is weak enough for Communism to get control, then the Indian people will just have to suffer for it and in the course of the next few hundred years it will all work out. If you point out that if Communism comes in it will result in perhaps a million or ten million people being killed in one fashion or another, still the answer is the same, that there is no reason for being unduly concerned about the lives of that number when there are 300 million here now and the population increasing every day. It simply is the price they feel they will have to pay if they have not been strong enough morally and philosophically to resist the infiltration and propaganda.

I suppose the one thing that Americans find hardest to understand about the Indians is the intense reaction to our giving aid to Pakistan. Pakistan is small in comparison to India and has only about one-fifth the population. To us it seems absurd that India should fear Pakistan, no matter how much arms are given. And yet there can be no doubt, if one talks to many Indians, that they do actually fear that these arms will be used against India. There has been strong animosity between the Hindus and Muslims going back to the Mogul invasions, and one has to remember that India was controlled for several hundred years by the Muslims, who will always be considered outsiders by the Hindu Indians. All these pent up emotions, many of which had been fanned unnecessarily, were released at the time of partition when the British Government handed over control of the country and it was split at the same time into two countries. No doubt both sides were responsible for the slaughter that took place. We were not here at that time but could still

see plenty of signs of it when we arrived seven months later. No one will ever know the number of people that were killed on both sides, but it is well up in the millions, estimates running from one and a half to six or seven million. The largest mass migration in history took place with about six million Sikhs and Hindus leaving Pakistan to come to India and an equal number of Muslims leaving India to go to Pakistan, and in almost every instance it meant leaving all they possessed except what they could carry on their backs. When we stop to think of this short but intense civil war that was fought not between armies but between civilians, it is asking a lot to have this all forgotten in seven years. This was a far larger holocaust than our Civil War, and yet a little of that smoke remains 90 years later! If anyone would like more of the background, I can heartily recommend the book by Brown, *India, Pakistan and the United States*.

We wish that some of you would come out and see this part of the world for yourselves. In the winter time the climate is wonderful. We have seen a few friends from home including Dr. Aub, who was here on a WHO teaching mission, along with Dr. John Gordon of the School of Public Health. The latter comes quite frequently to inspect some research projects that he has going out here. Dr. Bernard Briggs of the M.G.H. is expected to join the Vellore staff before you read this, on a Fulbright professorship, but we would like to see more of you.

It has been an interesting and rewarding experience to be here the last seven years and to see the encouraging changes that are taking place both in the nation and in individuals. Although it is not difficult to find fault with missionary enterprises and with missionaries themselves, they are trying to put into practice those Christian principles which are the only cure for this world's disease. Only when we care for others as we care for ourselves will the world become a better place.

How to Choose Your Doctor

Alfred A. Weinstein, '33

The guide posts in life are many. And it is good that you have them so that your living may give you contentment and a sense of accomplishment.

But nowhere can there be found a book, pamphlet, or guide to help you choose your Doctor and *teach you how to keep him after you have found him.*

To make matters more confusing, the last 25 years have seen the advent of extensive specialization in medicine resulting in an increase in the number of different kinds of M.D.'s. And the end of this trend is not yet visible, even if it were desirable. For the factors which brought the specialist into the fore of American medicine are still operative.

First, the fund of knowledge from research delving into the cause and treatment of disease has been so extensive that it is beyond the capacity of any one individual physician to absorb. Any special field, surgery for example, has been split into many subspecialties: orthopedics, urology, gynecology, neurosurgery, eye, ear, nose and throat, chest, cardiac, plastic and reconstructive. Since knowledge continues to accumulate on many surgical fronts, it is certain that new surgical subspecialties will be created. They have also developed in the fields of medicine, pediatrics and obstetrics.

The second factor which has stimulated the growth of the medical specialist was the American Public itself. For the concept of specialization is inherent in the development of the assembly line and industrial

mass production. The old-time "Jack of all trades and master of none" is no longer needed or wanted in American industry. His place has been filled by specialists, trained to do a specific job and paid well for doing it. At the employment bureau a man does not list himself as a steel worker, but as a melter, roller, crane operator, manipulator, or finisher. In the textile mill he asks for a job as a spinner, weaver, doffer, card tender, or loom battery filler.

It was easy therefore for these workers, their wives, and employers to apply the same principles of choosing a specific man for a specific job to the choice of a medical specialist. Superficially the analogy was obvious. John suffered loss of hearing in one ear. He went to the Ear M.D. for treatment (although this offending wax in his ear canal could have been removed by non-specialists). Jim went to the cardiologist because of the pain in the region of his heart (caused by arthritis of the cervical spine). Tom went to the Throat M.D. for relief of pain in the root of his neck (which was due to angina pectoris). Henry went to the orthopedic specialist for treatment of pain radiating down his right leg (which was due to diabetes).

John, Jim, Tom and Henry grumbled when the specialists failed to confirm the diagnoses the patients themselves had made. They grumbled when he referred them to other specialists for further study. They also grumbled about the cost of the specialist's diagnostic methods. Before long they grumbled about the whole medical profession. They had failed to realize a basic fact: that medicine does not have the watertight compartmentalization of industry. But they continue to sharpshoot in their choice of specialists

(and also boast to their friends that they are going to the "biggest" specialists in town).

The final impetus to the growth of medical specialization was the creation of hospitals throughout the country. Hospital staffs were created to which *at first all M.D.'s* could affiliate (who were licensed to practice by the state). Ostensibly in the interests of raising the standards of treatment in the hospital, new membership to the staff became *limited oftentimes to those men who were specialists* and certified as such by various Boards of specialists. Thus in many hospitals a hemorrhoidectomy (the operation first done by all student surgeons) could be done only by a surgical specialist. A delivery (95 per cent of all women will deliver themselves) could be carried out only by a specialist in obstetrics. And a patient sick with pneumonia (with antibiotics few need die of this disease) could be treated only by an M.D. who has passed the Board of Internal Medicine.

Thus recent graduates of medical schools were faced with a series of troublesome facts which bore heavily on their choice of a career in any urban or suburban area of the United States: (1) Medical knowledge was too vast for one man to encompass. He had to become a specialist himself or learn how and when to use specialists in the care of his patients. (2) In spite of sweet talk about the old "family doctor," the American public was side-stepping the general practitioners and picking their own specialists. (3) Unless he was a specialist it was becoming increasingly difficult for the new physician in town to become affiliated with a hospital in order to admit his patients for treatment.

Yet many recent graduates of medical schools, in spite of this pres-

Editor's note: Dr. Weinstein's contribution, although written for a lay audience, is printed herewith because it seems a clear and simple exposition of a subject which has received confused and occasionally hysterical treatment in a variety of publications both lay and medical. The editors welcome comments or addenda from the readership.

sure toward specialization, preferred to do general practice and become personal physicians. In an attempt to improve the status of the G.P. in the medical profession, many hospitals now have a department of general practice to which a physician may apply for affiliation. These M.D.'s may also apply for and gain membership in the Academy of General Practice. These new physicians differ in many respects from the old-time family doctor. (1) They are all graduates of Grade A medical schools. (The Grade B and C medical schools, most of which were privately owned, are no longer in existence.) (2) They have had at least one, and sometimes three or four years of post-graduate training in leading hospitals affiliated with medical schools. (3) They must attend hospital staff meetings and local and regional medical meetings to keep up with advances in medicine in order to maintain their status as members of the Academy of General Practice. (4) They have the knowledge and the equipment (blood-testing laboratories, cardiographs, metabolism machines) to help in diagnostic studies that the old-time M.D. had to do without.

This well-trained, alert, personal physician (P.P. rather than G.P.) is, in my opinion, the answer to the problem of how to choose a physician, and how to get good medical care at a price you can afford.

America is a nation which has been and is made up of restless people. There have been and will continue to be enormous shifts of population. The southerner has moved northward, the easterner has moved westward. The day has gone and will never return when the same physician will treat two and three generations of the same family. How, then, can you who have moved from one part of the city to another, or you who have moved from the country to the metropolis, find a personal physician and make of him your friend? Shall you rely on your grocer, maid, employer, elevator boy or garage attendant; or should you wait for an emergency and then rely

on your Municipal Hospital for care?

Of course not. To protect your life and that of your beloved family, you want your own physician, one who is friendly, alert, attentive, available at your home as well as at his office. And the people who are trained to help you choose him are in existence and anxious to serve you. They are the Secretaries of the City and County Medical Societies scattered throughout the land. These Medical Societies are voluntary associations of doctors. Among their many functions and duties, they help physicians continue their post-graduate training by making lectures, demonstrations and Medical Libraries available to their members. They associate with hospitals to raise the standards of medical and hospital care. They cooperate with the local newspapers in releasing press information on advances in the cure and treatment of disease. They also maintain a list of physicians (who are members of the American Medical Association) according to the type of medical practice in which they are engaged.

The first move, therefore, in the choice of your physician is this:

(1) Call Information. Ask the operator for the telephone number of the local Medical Society (either City or County).

(2) Tell the secretary at the Medical Society that you, Mr. Peters, want help in choosing a personal physician who will also take care of your family. She will recommend two or three men who practice in your neighborhood and give you their addresses and phone numbers.

(3) Call the secretary of one of these M.D.'s. Tell her you were referred by the local Medical Society. You are new in town (or new in the neighborhood) and want a personal physician. Ask her if the doctor makes house calls. (If he doesn't, he cannot make house calls. (If he doesn't, he cannot meet your requirements.) Some doctors do not make house calls because of failing health, age, or overwork at the office. It is not because they are lazy. Doctors work on an

average of 60 or 70 hours a week. This does not include compulsory attendance (at night) at hospital, staff, and Medical Society Meetings. Specialists rarely make house calls because they can best serve their patients by using diagnostic and therapeutic measures available only at the office and hospital.

(4) Make an appointment for a brief examination. This will include a physical examination. (stripped down), and blood and urinalysis. You will be pleasantly surprised to learn how little this costs. The patient who asks for a *complete examination* must understand clearly what he is asking for, and must be prepared to pay for the services rendered. These include metabolism, cardiogram, fluoroscopy of the heart, X-rays of the chest, stomach, gall-bladder and large bowel, and multiple blood chemistry tests. The charge for each of the above ranges from \$5.00 to \$25.00 each. It is the rare diagnostic problem the solution of which requires all these studies. More often it is the extremely apprehensive patient who demands them all and then fusses about the charges when the tests turn out to be negative. Ordinarily your personal physician will be guided by his preliminary physical examination before embarking on any special studies.

(5) Don't be ashamed to discuss charges with your doctor or his secretary *before* the services are rendered. You are entitled to know what they are so that you can budget yourself accordingly. Your doctor will be pleased to hear you ask about charges because he will then know that you are not a "deadbeat" (of which he has a splendid assembly) but that you intend to pay your bills.

Thus far you have located and been examined by a physician who you hope will be your personal family physician. Let us call him Dr. Thompson. You found him to be somewhat young in years, but thorough. He listened to your story and made a record of your history. He examined you and explained the details of his examination. He told you his charge and you paid him, or

made arrangements to pay. He knows you expect to call him day or night in any emergency, and you know he will respond. If he is out of town or ill, he has told you where you can reach his medical associate who covers his calls for him when he is not available.

Months pass. Dr. Thompson treats you at home for acute bronchitis. Your daughter June sees him because of adolescent skin blemishes. You son Dicky is treated for a sprained ankle. You find your doctor to be friendly, available and alert. His service is good. His charges are in line. His treatment is effective. He and the Peters family are becoming friendly.

You congratulate yourself on having taken the advice of the secretary at the Medical Society in the choice of a personal physician. But you, Mr. Peters, now approach a time of crisis in your relationship with your doctor. You have selected one who you think is good. *But can you hold him as your own?* Your wife develops varicose veins that require an operation. Dicky comes down with a congenital hernia, June fractures a wrist. You have the misfortune of developing a heart attack. In each instance you call Dr. Thompson. He makes the right diagnosis, and advises proper treatment. Friends and relatives call you or appear in increasing numbers at your home, each advising you to get vein, hernia, bone and heart specialists.

What you do at this point determines whether you have retained or lost a personal physician. It is true you have every legal right to dismiss Dr. Thompson and replace him with another physician. But before being stampeded by your relatives or your own fears, think it over and discuss the matter with your personal physician. It might help you to solve your problem if you know that the present-day medical school graduate has had two or three years of post-graduate training (he receives hospital training in medicine, surgery and obstetrics). He has the diagnostic acumen and technical skill to handle efficiently 80 to 85 per cent

of all the patients who come to him for treatment. Included among them are the medical and surgical problems that affected the Peters family.

Your cue then, Mr. Peters, is to ask Dr. Thompson directly if he wants to handle the case himself or transfer it. Dr. Thompson will say he is equipped to handle this type of problem himself, but will transfer the case *if you want him to*. Here then is the crux of the matter. You can retain a personal physician and tie him closely to you for your protection only if you have confidence in his judgment and acumen. If you offend him by rejecting him and thus casting aspersions on his ability, you will not be able to retain him as your personal physician.

If, however, your wife's varicose veins are due to pressure from an intra-abdominal tumor; and Dicky's hernia is incarcerated or strangulated; and June's fractured wrist is comminuted and compounded (fragments projecting through the skin); and your heart attack is complicated by cardiac failure, arrhythmias and shock, the gravity of this patient-picture becomes self-evident.

Dr. Thompson himself will advise calling in consultant specialists. He will ask you to choose one of several. You'll be smart to tell him to make the choice. He knows the *professional* qualifications of the specialists in town better than your neighbors, business associates, close relatives, or casual contacts. For *Dr. Thompson still feels responsible for the recovery of the patients, even though he uses the instrumentality of a specialist rather than his own treatment*. And he will carry on as your friend and personal physician to the family in your emergency.

He will call the specialist, present the present problem and any relevant past history. He will, if possible, be present when the specialist makes his examination. He will help interpret the consultant's decision. If possible, he will be present at the operation. He will interpret the results of the operation to the family and reassure and steady its members during the period of crisis. He will

record the details of the illness in his personal files. And he will give the specialist adequate information, so that the fee he sets for his services will be commensurate with the income of the head of the family.

By following these simple rules of good sense and courtesy you will have retained the friendship and good will of your personal physician. You have given him the feeling that you look to him at all times to be the protector of that which is dear to you, the lives of your family, and your own health. And to the extent that you load him with this responsibility, to that degree will he be complimented and accept your confidence as a sacred trust.

As the years pass, you may find Dr. Thompson referring you and members of your family to many specialists; either for diagnosis or treatment beyond his knowledge and for problems not necessarily acute in nature. In each instance, however, he will previously pass on to the consultant the details of your past history and present illness. The specialist himself is more than grateful for this information because it helps him in solving the problem of diagnosis and treatment. He therefore prefers to see patients who have been previously screened by their personal physician. For it enhances his chances of presenting the patient with a positive diagnosis in exchange for his fee rather than with a negative examination, which is often the case when the patient attempts to match his own symptoms with the proper specialists.

Just as American industry is molded by public demand, so has medical practice been modified by similar pressure. American medical schools and hospitals are again beginning to turn out in increasing numbers, physicians trained to be personal physicians. Whether they continue to do so depends upon whether the American public will give these young doctors its confidence, loyalty and affection. They are now available. You know how to reach and keep them if you really want them.

Medical Panel at Associated Harvard Clubs Meeting

Editor's Note: The following is abstracted from a report by Dr. J. Roger Newstedt, '42. It seems to us an excellent example of the role of Harvard in the dissemination of information of current interest and importance in a manner both compact and informative.

During the recent 58th Annual Meeting of the Associated Harvard Clubs in Cincinnati, Ohio, the section on Medicine and Public Health held a panel discussion in the Netherland Plaza Hotel on the broad subject: "Informal Considerations of Viruses and Tissue Culture Techniques." The panelists were Dr. George Packer Berry, Professor of Bacteriology and Dean of the Faculty of Medicine, Dr. John F. Enders, M.A. '22, Ph.D. '30, Associate Professor of Bacteriology and Immunology, Dr. Frederick C. Robbins, M.D. '40, Professor of Pediatrics, Western Reserve Medical College, Dr. John C. Snyder, M.D. '35, Dean of the School of Public Health, and Dr. Thomas H. Weller, M.D. '40, Richard Pearson Strong Professor of Tropical Public Health. As guests, the panel also included Dr. Stanley E. Dorst, Dean of the University of Cincinnati College of Medicine, and Dr. Albert B. Sabin, Professor of Research Pediatrics, University of Cincinnati College of Medicine.

The meeting was opened by Dr. Robert C. Rothenberg, '24, who served as chairman of the committee on Medicine and Public Health of the Harvard Club of Cincinnati. He noted the tendency in Harvard affairs to look back with pride at past achievement and also to look forward into the future with confidence of even greater things to come. But he noted the University can also stop to deal with the present. He recalled that Sir William Osler, during his last visit to the United States during 1913, took occasion to emphasize the importance of dealing with the present by quoting a poem said to be

originally from the Sanskrit, a portion of which follows:

"For yesterday is but a dream
and tomorrow is only a vision.
But today, well lived, makes
every yesterday a dream of
happiness and every tomorrow
a vision of hope.
Look well, therefore, to this
day."

He then introduced Dr. Berry, who acted as moderator of the panel thereafter.

Dr. Berry outlined the course of the informal discussion which was to follow and noted some of the modern ways that are opening up vistas that could not be contemplated with any encouragement just a few years ago. He recalled that it was in the early 1890's when Iwanowski and Behring and others first identified agents that could not be seen, could not be grown, but which, nevertheless, put into proper animal or plant environment produced a disease that could be passed along from host to host. Because these agents could only be separated out from their environment by filtration, they came to be known as filtrable viruses. He introduced Dr. Frederick C. Robbins to comment on the rapid growth of knowledge that has occurred in the half century since that time.

Dr. Robbins opened the symposium with an historical review of the study of viruses. He pointed out that although tissue culture as a means of studying viral infections has assumed a great importance in recent years, the method is not new, and as a matter of fact the first virologists who attempted to use tissue cultures in this way began as long ago as 1907.

It was only, however, with the discovery that poliomyelitis virus would grow in human embryonic fibroblasts and epithelial cells, as well as in central nervous system tissue, that the culture of this organism and

the preparation of immune serum became possible on a large scale.

Dr. Berry, after commenting on the re-establishment of a surgical service by Harvard Medical School in the Boston City Hospital, then introduced Dr. Sabin to report on some of the developments in his laboratory in Cincinnati. Dr. Sabin paid tribute to the important forward steps that had been made by Doctors Enders, Weller, and Robbins in the past few years, which had made possible all of the progress in his laboratory as well as in numerous laboratories throughout the world. "I will never forget how little attention the report, first made in 1950, I believe, by Dr. Robbins, Dr. Weller, and Dr. Enders, on the so-called cytopathogenic effect of the poliomyelitis virus, received. I must tell this story because I never fail to be impressed by it. It was submitted to the Society for Clinical Investigation and they did not regard it of sufficient importance to put it on the regular program, so they put it 'read by title.' But that paper, that first report, became the turning point which has made possible the most exciting laboratory work in new fields today." In poliomyelitis for many years there has been a question as to why in nature so many are infected and so few are paralyzed. He expressed his long-term suspicion that in nature we are confronted with a variety of poliomyelitis viruses which might be distinguished as being "good" viruses and "bad" viruses. A good poliomyelitis virus is one which produces infection and immunity but does not cause paralysis, whereas the bad virus is one which extracts a price in paralysis that may be anywhere from 1 to 50 to 1 to 1000 of those infected. It was felt that the march of these highly virulent poliomyelitis viruses among populations that had been insufficiently immunized by the dissemination of the good viruses was what led to epidemics.

This beautiful hypothesis could not be tested until the techniques developed by Dr. Enders' group provided a means and one such study was started in Cincinnati in 1953 and continued in Mexico last year in which rectal swabs were taken from healthy children. "We found that the incidence of poliomyelitis viruses in Mexico particularly was so high in children one to four years of age that in Mexico City about 3.5 per cent of healthy children in an isolated sampling had poliomyelitis, and in varied groups about 8.5 per cent. In Cincinnati the incidence in varied groups was about 5 per cent." The studies indicate that there are indeed important poliomyelitis viruses which we may call good viruses and these viruses are now being studied in the experimental laboratory to determine if they can be used for immunization against poliomyelitis by techniques that are intended to simulate what occurs under natural conditions.

Dr. Berry then mentioned that it was just 50 years ago that the faculty of medicine in the basic sciences joined itself together very closely with the science departments in Cambridge and from the integration of these two departments "many distinguished individuals have emerged who have devoted themselves to exploring the mystery of cellular activity." Dr. Enders was mentioned as one of the alumni of this division of the medical sciences and the fourth of these alumni to win a Nobel Prize. He mentioned that Dr. Enders' work had moved rapidly into other areas and most recently he has been concerned with measles.

Dr. Enders recollected that his interest in measles began at least as far back as 1938, but it was not until the newer techniques of tissue culture were developed that it was possible to make very much progress with the disease. In the past year, cultures of human kidney tissue were used; the kidney tissue was obtained from kidneys removed at operation in the treatment of hydrocephalus. It was the use of such tissues that

made possible the study of the effect of immune serum upon the virus of both measles and poliomyelitis.

Another extraordinarily useful method of localizing either antigen or antibody in tissues or cells is that which depends on the use of an antibody in which a fluorescent molecule has been introduced by chemical means. The fluorescent antibody after uniting with the antigen in a tissue or cell will be visible under the fluorescent microscope.

Dr. Weller then presented a brief review of his work with chicken pox and herpes zoster and following this Dr. Snyder gave a resume of the proposed work on trachoma which will be carried out in Saudi Arabia with the ultimate objective of finding a means to prevent this disease.

The meeting ended with a number of questions offered from the floor and an interesting digression arose from this discussion out of the remarks of Dr. Berry concerning the

"real meaning of this extraordinary 'explosion' of excitement about the use of a formalized vaccine as an immunizing agent." At a time when wide-spread public support is essential for the march of science, it is also equally important that some means be found of using the power for mass communication to disseminate information accurately and quickly, but in such a way that the impact is not misleading. Rather than to condemn this or that or the other agency involved, it would be much more fruitful to try to find out how to use the combined efforts of the laboratory and the physician, the public health service, and the government to prevent this kind of public health problem from entering a state of excitement or hysteria the next time. "If we fail to take the means of doing so, I think we will have missed one of the opportunities we have had from this symposium this afternoon."

NEW APPOINTMENT

William F. Ketchum, '44, has been appointed Assistant to the Dean of Harvard Medical School, it was recently announced by Dr. George Packer Berry. Dr. Ketchum, who was graduated from Harvard College *summa cum laude* in 1941, and received his medical degree *magna cum laude*, will deal in his new position with problems ranging through the academic spectrum, involving both students and Faculty. He will also hold a teaching appointment at Children's Hospital, serving as instructor in pediatrics on a part-time basis.

Dr. Ketchum brings to his new post a variety of experience. After serving a medical internship at the Peter Bent Brigham Hospital, he spent two years in the Army Medical Corps. Following this, he returned to Boston for further training at the Massachusetts General Hospital and the Children's Hospital,

and then became chief resident at Babies' Hospital in New York. Subsequently he was in practice and served as an assistant in pediatrics at Tulane University School of Medicine. He also held a National Foundation for Infantile Paralysis post-doctorate fellowship in the Department of Biological Chemistry at Harvard Medical School, and is a Diplomate of the American Board of Pediatrics.

In regard to Dr. Ketchum's appointment, Dr. Berry said, "In his work in the Dean's Office, Dr. Ketchum will concentrate on student affairs—curriculum, student-teacher relationships, student life in Vanderbilt Hall, and so on. Because of his own experiences at Harvard, and his broad training and hospital teaching, I feel that he can greatly strengthen the opportunities we are trying to provide for our future physicians."



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Inside H. M. S.

LONDON HOLIDAY

Hugh McDewitt and John Goldstone, '55

In the summer of 1954, several of us who were just beginning our fourth year at H.M.S. arranged to take courses in England. What prompted this exodus is not very clear, but the administration's unexpected willingness to lend us the price of a round-trip fare changed a pipe dream into a possibility and set us all writing letters in search of a student's berth at one of the London teaching hospitals. When arrangements were complete, Milt Viedermann and Bill Bolman were scheduled to take two months of pediatrics at St. Mary's, while Maury Soltes elected two months of surgery at St. Mary's, and we chose a month each of pediatrics and medicine at Guy's Hospital. This choice was based on a dim recollection that Guy's was the oldest hospital in London, and a feeling that we might as well go to the true fount of English medicine as long as we were going at all. It turned out that Guy's was not the oldest (having been founded in the 1700's), but was one of the most revered of London's hospitals.

Its origins extended back to the 13th century, when there grew up at the foot of London Bridge an almshouse where the poor, the maimed, and the sick entering and leaving London were fed and cared for. This informal institution continued existence as St. Thomas's Hospital, a way station for London's incurables until the early 18th century, when Thomas Guy, a merchant and Governor of St. Thomas's, who had grown rich trading in London, gave large sums of money to build and equip a sister "Hospital for Incurables," using the older institution as a starting point. As the centuries passed, the new hospital grew with the city, acquired independence, added a medical school, and became one of London's foremost medical centers. The hospital wards are named after its elder statesmen, among them Gull, who was one of the first to describe myxedema; Bright, Addison, Cooper, and many others.

Our position and function as students soon became clear. After considerable questioning, we finally got an idea of how British medical education operates. The

students who are entering medical school fall into two general groups—those who have gone to state or locally supported schools, and those who have gone to public (actually privately supported) schools and on to Cambridge or Oxford. The first group begins to specialize in the biological and pre-medical sciences at age 16 and after two years of this comes straight to medical school at 18. The second group attends a public school up to age 18, and follows this with three years at Cambridge or Oxford or their equivalent, majoring in pre-medical courses. Medical school itself requires about five and one-half years. The first year is pre-medical, including physics, chemistry, and biology. The next year and one-half covers the pre-clinical courses and then there are three years of clinical ward work. The student is called a ward clerk and, depending on what stage of development he has reached, may be called a junior or senior ward clerk. The unit of organization within which the student works and learns is a "firm." A firm has a certain number of beds in certain wards, but otherwise it consists only of the people in the firm—namely two or three consultants, a chief registrar, assistant registrar, two house officers, five or six senior ward clerks and five or six junior ward clerks. At Guy's, such a firm had 60 beds, and each student was expected to carry about five patients. Admissions were allocated on a weekly basis, each of four medical firms being on "take-in" for a week straight. The next three weeks are spent in rest, recuperation, and a leisurely work-up of the patients admitted while on "take-in." One of the most pleasant things we found about Guy's was this relaxed approach to life in general. Ward work starts at 8:30 or 9:00, there is a one- or two-hour luncheon, and the day's efforts ended never later than 5:00. Only the house officers worked very hard, and even they in trousers and jackets. The tradition against white pants is unique at Guy's, and ward rounds seem oddly informal to the outsider.

Our days in pediatrics were about equally divided between ward rounds, OPD teaching, and semi-formal lectures given by the registrar. In most of these sessions, the firm would sit in a semicircle or 10 or 12 chairs while

the consultant or registrar would discuss a case or give a lecture. Almost always, at some point in the discussion, questions would be asked of the students. The British students responded to questioning in a fairly uniform way—they closed ranks and became extremely reluctant to divulge any information, whether they had it or not. This attitude was accompanied by a refusal to ask questions themselves, at least in a group, and most sessions could be counted on to break up as soon as the consultant said, "Any questions?" Our colleagues seemed to feel that it was bad to answer questions too readily or appear too curious—although in actuality they were as well-informed and as interested as a comparable group of U. S. students. They advised us not to be too outspoken with the instructors warning that the punishment would fit the crime. There were one or two episodes when a student's mention of some rare and exotic diagnosis brought tragedy in the form of a steady rain of questions and comments—old Dr. MacKeith with raised eyebrows would start in with, "Tell me about this disease, have you seen a case? Oh, you *haven't*. Hmmmm. Neither have I, but enlighten me." However, consultants were for the most part very gentle with their charges. They were very strict about careful observation and would often and repeatedly point out the need for complete examination. As we approached a patient's bedside one day, Dr. MacKeith told a small group of us to examine the foot. We stood for some time in mute admiration of what seemed to be a normal foot.

"What do you find?"

There followed a halting description of a small abraded area on the dorsum of the foot.

"Have you examined the foot?" Then it became clear.

Several hands leaped to the task, all too late. Dr. MacKeith slowly removed his hand, turned the foot on its side, and revealed to us a shower of petechiae on the sole.

"Gentlemen, when I ask you to examine the foot, I mean the whole foot."

The English students had had a good deal of this sort of teaching in their physical diagnosis course. There, they spent two weeks on the physical diagnosis of each system—cardiovascular, respiratory, and so on. They were first given lectures on what to look for, and were then provided with patients who were paid to let students examine them to their hearts' content. We were told that many of London's old tabetics derived their major source of income from the seven shillings a day with free lunch that every medical school paid. Those with particularly interesting findings also were regular performers at qualifying examinations—and it is not uncommon for a student who is in the midst of "qualifying" to run into an old friend from earlier days. This is usually regarded as a boon, giving him time to think about the other patients he has seen. But the system worked well, and we found that our classmates could teach us a great deal about the art of physical diagnosis. Perhaps because of this, as well as because of economy, the English tend to use laboratory tests much less than is done in the United States. Despite this, there were frequent complaints that the National Health Service had changed things, and that doctors abused their privilege and ordered too many lab tests.

One of the most striking differences that we noted between Boston and London was the patient, and especially the pediatric patient. Children are taught strict obedience to command and almost every child over the

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age of four knuckles under to "that needle" with no complaint, and a typical stiff upper lip. The same was true of the adult patients, who took a little discomfort as a matter of course. They were treated somewhat distantly by their physicians (although this may have been only English reserve) and accepted his orders without argument.

As he goes his gentlemanly way through medical school, the Englishman finds a great deal to occupy his spare time. Since many of the students come to medical school at 18, and the equivalent of our college education is given in the first year or two, the medical school serves many of the functions of a college. Even though the medical school is an integral part of a large hospital, the student body maintains its identity as a group. There are a bewildering number of student organizations—chess clubs, literary clubs, drama groups, boating societies, and so on. However, the most numerous and the most active groups are the various athletic teams. Every hospital fields a team in the inter-hospital competition among the 13 London medical schools, and the fortunes of Guy's at cricket or rugby were as important to our confrères as the Harvard-Yale game is to some of us. During the finals and semi-finals, whole firms evaporate and mass migrations to the hospital's athletic grounds outside the city take place. No thought is given to work left behind, and no registrar would dare demand attendance on such a day. It has even gotten to the point of granting athletic scholarships to medical school; another example of our English heritage, sheepishly admitted to by its originators. The practice is widely used, and it is alleged that St. Mary's, long an athletic powerhouse on the London medical scene, has had several students on its cricket rolls for the regulation six years who were unable to get beyond the first year exams.

Many of the students live at the medical school or in nearby "digs" where living is even cheaper. Almost every hospital has one favorite pub on which it bestows most of its trade and which is used by the students as a watering place. Evening rounds on "take-in" are solemnly interrupted at 10:25 by a quick dash across the street for two glasses of ale, following which the registrar leads his flock back to the yards. Our stay was spotted with long evenings in this pub wrangling over Anglo-American relations, medicine, and the usual bar-room topics. Our hosts were always cordial and very hospitable, but given an arguing point like Senator McCarthy, they pressed their advantage to the utmost.

At the end of our two-month stay we were struck more by the similarities between medical schools in Boston and London than by the difference. With the single exception that the English go at the whole affair in a more leisurely fashion, the approach to teaching and practicing medicine is very much like ours, but the differences in surroundings and outlook left us with a strong feeling that we would like to go back.



Dr. Robert M. Green demonstrating during a first-year anatomy lecture.

Dr. Robert Montraville Green, Associate Professor of Applied Anatomy, *Emeritus*, died on May 29th at the age of 74. Dr. Green was a graduate of Harvard College and received his M.D. from Harvard in 1906. At Harvard he majored in English and the classics, graduating *summa cum laude*. This interest was a valuable foil for his medical interests, and in later years he translated a number of Greek and Latin texts including Galen's *Hygiene*, published in 1951, and most recently Galvani's *Commentary on Electricity* which was published in 1953 and reviewed in the *Bulletin*.

Dr. Green served as a house officer at the Massachusetts General Hospital and later at the Children's Hospital and Boston Lying-in Hospital. He was surgeon-in-chief of gynecology and obstetrics at the Boston City Hospital from 1930 to 1942.

Generations of medical students came to know him for his beautiful demonstrations of anatomy. For forty years he taught this subject at Harvard Medical School. For many medical students "Bobby" Green's first lecture in anatomy was the initial contact with medical school. We will long remember his lectures, not only for the clarity of their scientific content, but for the grace and fluency with which they were de-

livered. His mastery of Greek and Latin and his erudition lent an aura to his person which was matched only by his soldierly carriage and the magnificent mustache.

The text for Warren's *Handbook of Anatomy* was written by "Bobby" Green. Few of us will forget his prose even though we may not remember the Latin names for the structures he described. Among his other literary achievements was a rendering into English verse of the Odes of Horace, and in the near future there will appear what he wrote was "My latest and largest literary production, 'The Round Table, an Arthurian Romance Epic,'

the preparation and composition of which have occupied my leisure for the past half century."

Dr. Green was editor-in-chief of the New England Journal of Medicine from 1915 to 1921, was a member of Phi Beta Kappa, the Aesculapian Club and the Harvard Faculty Club. In the eyes of the medical students, not the least of his many important posts was a lectureship in Greek at Simmons College.

With the passing of "Bobby" Green, New England has lost an important scholar and teacher, and Harvard Medical School a beloved and colorful contributor to Harvard legend and tradition.

NECROLOGY

1899

BENJAMIN LAZARUS died at Newton Center, Massachusetts, August 15, 1955.

1900

CHARLES HUNTER DUNN died at Poughkeepsie, New York, July 19, 1955.

1901

HORATIO CUSHING ALLEN died at New Bedford, Massachusetts, June 29, 1955.

DAVID CHEEVER died at Wellesley, Massachusetts, August 13, 1955.

ALBERT FARNSWORTH GRIFFITHS died at Bayside, New York, June 22, 1955.

PETER WILLIAM HESS died at Sangerville, Maine, August 6, 1955.

BERNARD WESLEY POND died at Newton, Massachusetts, August 1, 1955.

1902

JOSEPH HORACE DENNEN died at Hope Valley, Rhode Island, June 20, 1955.

1904

ELMER LOUIS BRINE died at Brookline, Massachusetts, July 12, 1955.

LORING GRIMES died at Lynn, Massachusetts, June 19, 1955.

1906

HENRY CHURCH PILLSBURY died at Ross, California, July 18, 1955.

1911

PETER JAMES DULLIGAN died at Queens, New York, July 29, 1955.

1917

EDWIN PORTER BUCHANAN died at Beverly, Massachusetts, July 11, 1955.

1919

WILLIAM RAYMOND SUPPLE died at Cambridge, Massachusetts, August 24, 1955.

1920

LEWIS ERNEST DANIELS died at Detroit, Michigan, August 8, 1955.

JOSEPH JAMES O'LEARY died at Newton, Massachusetts, July 20, 1955.

1922

WILLIAM WAUGH HAGGART died at Denver, Colorado, June 8, 1955.

1923

GARNETT CHENEY died at San Francisco, California, June 16, 1955.

1933

WILLIAM GRAHAM THOMPSON died at Andover, Massachusetts, August 13, 1955.

1949

WARREN JOSEPH WONKA died at Manhasset, New York, July 19, 1955.

Division of Medical Sciences

JAMES BATCHELLER SUMNER died at Buffalo, New York, August 12, 1955. Dr. Sumner took his Ph.D. in Biological Chemistry in 1914, doing work in the Harvard Division of Medical Sciences. He went on to crystallize the first enzyme, urease, for which he won the Nobel Prize in Chemistry in 1946. He was preceded in receipt of this award by Dr. E. A. Doisy, who won the Prize in 1943, and followed by Dr. John Enders, who became the third alumnus of the Division of Medical Sciences to be so honored, in 1954. Dr. Sumner had long served as professor of biochemistry at Cornell University.

